STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
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Good morning, Chairman Miller, Ranking Member Michaud and Members of the Committee. Thank you for the opportunity to discuss the provision of mental health care to Veterans, particularly those who are at risk for suicide. I am accompanied today by Dr. Harold Kudler, Acting Chief Consultant for Mental Health Services, Dr. David Carroll, Acting Deputy Chief Consultant for Specialty Mental Health, and Mr. Michael Fisher, Program Analyst, Readjustment Counseling Service. My written statement will provide a brief overview of VA's mental health care system and programs for suicide prevention.

Mental Health Care Overview

Since September 11, 2001, more than two million Servicemembers have deployed to Iraq or Afghanistan. Long deployments and intense combat conditions require optimal support for the emotional and mental health of Veterans and their families. Accordingly, VA continues to develop and expand its mental health system. The number of Veterans receiving specialized mental health treatment from VA has risen each year, from 927,052 in Fiscal Year (FY) 2006 to more than 1.4 million in FY 2013. We anticipate that VA's requirements for providing mental health care will continue to grow for a decade or more after current operational missions have come to an end. VA believes this increase is partly attributable to proactive screening to identify Veterans who may have symptoms of depression, posttraumatic stress disorder (PTSD), substance use disorder, or those who have experienced military sexual trauma (MST). In addition, VA has partnered with the Department of Defense (DoD) to develop the VA/DoD Integrated Mental Health Strategy to advance a coordinated public-health model to improve access, quality, effectiveness, and efficiency of mental health services for Servicemembers, National Guard and Reserve, Veterans, and their families.

VA has many entry points for VHA mental health care, through 150 medical centers, 820 Community-Based Outpatient Clinics (CBOCs), 300 Vet Centers that

provide readjustment counseling, the Veterans Crisis Line, VA staff on college and university campuses, and other outreach efforts. To serve the growing number of Veterans seeking mental health care, VA has deployed significant resources and increases in staff toward mental health services. Since March 2012, VA has added 2,444 mental health full-time equivalent employees and hired 915 peer specialists and apprentices. As of January 2014, VHA has 21,128 Mental Health full-time equivalent employees providing direct inpatient and outpatient mental health care. VA has expanded access to mental health services with longer clinic hours, telemental heath capability to deliver services, and standards that mandate immediate access to mental health services to Veterans in crisis. Starting in FY 2012, site visits have been conducted to the mental health programs in each VA facility. All facilities were visited in the initial round, and subsequently one third are being visited each year by a survey team from VHA's Office of Mental Health Operations. The site visits are informed by ratings on performance measures; findings from the visits are used to develop action plans; and improvements are evaluated by following performance measures as well as the milestones and deliverables included in the plans. In an effort to increase access to mental health care and reduce any stigma associated with seeking such care, VA has integrated mental health into primary care settings. From the beginning of FY 2008 to March 2014, VA has provided more than 3.6 million Primary Care-Mental Health Integration (PC-MHI) clinic visits to more than 942,000 unique Veterans. This improves access by bringing care closer to where the Veteran can most easily receive these services, and quality of care by increasing the coordination of all aspects of care, both physical and mental. Among primary-care patients with positive screens for depression, those who receive same-day PC-MHI services are more than twice as likely to receive depression treatment as those who did not.

VA has made deployment of evidence-based therapies a critical element of its approach to mental health care and offers a continuum of recovery-oriented, patient-centered services across outpatient, residential, and inpatient settings. State-of-the-art treatment, including both psychotherapies and biomedical treatments, are available for the full range of mental health problems, such as PTSD, substance use disorders, and

suicidality. While VA is primarily focused on evidence-based treatments, we are also assessing complementary and alternative treatment methodologies that need further research, such as meditation and acupuncture in the care of PTSD. VA has trained over 5,900 VA mental health professionals to provide two of the most effective evidence-based psychotherapies for PTSD, Cognitive Processing Therapy and Prolonged Exposure Therapy, as indicated in the VA/DoD Clinical Practice Guideline for PTSD[1]VA operates the National Center for PTSD, which guides a national PTSD mentoring program, working with every specialty PTSD program across the VA health care system. The Center has begun a PTSD consultation program for any VA practitioners (including primary care practitioners and Homeless Program coordinators) who request consultation regarding a Veteran in treatment with PTSD. So far, over 500 VA practitioners have utilized this service.

We know that there have been Veterans with complaints about access. We take those concerns seriously and continue to work to address them. Receiving direct feedback from Veterans concerning their care is vitally important. During the fourth quarter of FY 2013, a survey of 26 questions was mailed to over 40,000 Veterans who were receiving mental health care. This survey shows VHA's effort to seek direct input from Veterans in understanding their perceptions regarding access to care. We recognize that this is data only from those who chose to respond. We will bear those responses in mind as we strive to improve the timeliness of appointments; reminders for appointments; accessibility, engagement, and responsiveness of clinicians; availability and agreement with clinician on desired treatment frequency; helpfulness of mental health treatment; and treatment with respect and dignity.

Programs and Resources for Suicide Prevention

Overall, Veterans are at higher risk for suicide than the general U.S. population, notably Veterans with PTSD, pain, sleep disorders, depression, and substance use disorders. VA recognizes that even one Veteran suicide is too many. We are

[1] http://www.healthquality.va.gov/guidelines/MH/ptsd/cpg_PTSD-FULL-201011612.pdf

committed to ensuring the safety of our Veterans, especially when they are in crisis. Our suicide prevention program is based on enhancing Veterans' access to high quality mental health care and programs specifically designed to help prevent Veteran suicide.

In partnership with the Substance Abuse and Mental Health Services Administration's National Suicide Prevention Lifeline, the Veterans Crisis Line/Military Crisis Line (VCL/MCL) connects Veterans and Servicemembers in crisis and their families and friends with qualified, caring VA responders through a confidential toll-free hotline that offers 24/7 emergency assistance. August will mark seven years since the establishment of the initial program, which was later rebranded to show its direct support for Servicemembers. It has expanded to include a chat service and texting option. As of March 2014, the VCL/MCL has rescued 37,000 actively suicidal Veterans. As of March 2014, VCL/MCL has received over 1,150,000 calls, over 160,000 chat connections, and over 21,000 texts; it has also made over 200,000 referrals to Suicide Prevention Coordinators (SPCs). In accordance with the President's August 31, 2012, Executive Order titled, "Improving Access to Mental Health Services for Veterans, Service Members and Military Families," VA completed hiring and training of additional staff to increase the capacity of the VCL/MCL by 50 percent.

VA has a network of over 300 SPCs located at every VA medical center and the largest CBOCs throughout the country. Overall, SPCs facilitate implementation of suicide prevention strategies within their respective medical centers to help ensure that all appropriate measures are being taken to prevent suicide in the Veteran population, particularly Veterans identified to be at high risk for suicidal behavior. SPCs receive follow-up consults from the VCL/MCL call responders after immediate needs are addressed and any needed rescue actions are made. SPCs are required to follow up on consults received from the VCL/MCL within one business day to ensure timely access to care for Veterans callers who need additional support, treatment, or other services, including enrollment into VA's health care system. SPCs also plan, develop, implement, and evaluate their facility's Suicide Prevention Program to ensure continual quality improvement and excellence in customer service. SPCs are responsible for implementing VA's *Operation S.A.V.E* (Signs of suicidal thinking, Ask the questions,

Verify the experience with the Veteran, and Expedite or Escort to Help). This is a one-to-two hour in-person training program provided by VA SPCs to Veterans and those who serve Veterans to help prevent suicide. Suicide prevention training is provided for every new VHA employee during Employee Orientation.

SPCs participate in outreach activities, which remain critically important to VA's goals of reducing stigma for mental health issues and improving access to service for all Veterans. Examples include community suicide prevention training and other educational programs, exhibits, and material distribution; meetings with state and local suicide prevention groups; and suicide prevention work with Active Duty/National Guard and Reserve units as well as college campuses. To date, each SPC is required to complete five or more outreach activities in their local community each month.

Veterans may be at high risk for suicide for various reasons. Determination of suicide risk is always a clinical judgment made after an evaluation of risk factors (e.g., history of past suicide attempts, recent discharge from an inpatient mental health unit), protective factors, and the presence or absence of warning signs. VHA Handbook 1160.01, "Uniform Mental Health Services in VA Medical Centers and Clinics," requires inpatient care be available to all Veterans with acute mental health needs (including imminent danger of self harm), either in a VA medical center or at a nearby facility through a contract, sharing agreement.

To ensure that high-risk Veterans are being monitored appropriately, SPCs manage a Category I Patient Record Flag (PRF) with a corresponding High-Risk List. The primary purpose of the High Risk for Suicide PRF is to communicate to VA staff that a Veteran is at high risk for suicide, and the presence of a flag should be considered when making treatment decisions. Once a Veteran is identified as high-risk, the SPC ensures that weekly contact is made with the Veteran for at least the first month, and that continued follow-up is made, as clinically appropriate. The SPC works with the treatment team to ensure that patients identified as being at high risk for suicide receive follow up for any missed mental health and substance abuse appointments at VA. Clinicians are required to initiate at least three attempts to contact Veterans on the High-Risk List who fail to appear for mental health appointments and ensure appropriate

documentation. If attempts to contact the Veteran are unsuccessful, the SPC collaborates with the Veteran's treatment team to decide what further action is appropriate involving a range of options from continued outreach efforts to the Veteran and/or family members up to requesting local law enforcement perform a welfare check in-person.

SPCs ensure that all Veterans identified as high risk for suicide have completed a safety plan that is documented in their medical record, and that the Veteran is provided a copy of his or her safety plan.

National suicide prevention outreach efforts continue to expand and include targeted efforts for Veterans, Servicemembers, families, and friends. VA has sponsored public service announcements, rebranded and optimized the VCL/MCL Web site for mobile access and viewing, and developed social and traditional media advertisements designed to inform Veterans and their families of VA's VCL/MCL resources including phone, online chat, and text services.

In addition, VA has established an online Community Provider Toolkit[2] for individuals outside of VA who provide care to Veterans. This Web site features key tools to support the mental health services provided to Veterans including information on connecting with VA, understanding military culture and experience, and working with patients with a variety of mental health conditions. There is also a comprehensive Suicide Prevention Mini-Clinic which provides clinicians with easy access to useful Veteran-focused treatment tools, including assessment, training, and educational handouts.[3]

In 2010, DoD and VA approved plans for a Joint Suicide Data Repository (SDR) as a shared resource for improving our understanding of patterns and characteristics of suicide among Veterans and Servicemembers. The combined DoD and VA search of data available in the National Death Index represents the single largest mortality search of a population with a history of military service on record. The DoD/VA Joint SDR is

[2] http://www.mentalhealth.va.gov/communityproviders
[3] http://www.mentalhealth.va.gov/communityproviders/clinic_suicideprevention.asp

overseen by the Defense Suicide Prevention Office and VA's Suicide Prevention Program.

On February 1, 2013, VA released a report on Veteran suicides, a result of the most comprehensive review of Veteran suicide rates ever undertaken by VA. With assistance from state partners providing real-time data, VA is now better able to assess the effectiveness of its suicide prevention programs and identify specific populations that need targeted interventions. This new information will assist VA in identifying where at-risk Veterans may be located and improving the Department's ability to target specific suicide interventions and outreach activities in order to reach Veterans early and proactively. These data will also help VA continue to examine the effectiveness of suicide prevention programs being implemented in specific geographic locations (*e.g.,* rural areas), as well as care settings, such as primary care, in order to replicate effective programs in other areas. VA continues to receive state data which is being included in the SDR. VA plans to update the suicide data report later this year.

In 2011, the most recent year for which national data are available, the age-adjusted rate of suicide in the U.S. general population was 12.32 per 100,000 persons per year. At just over 12 for every 100,000 U.S. residents, the 2011 rate of suicide has increased by approximately 15 percent since 2001. Rates of suicide in the United States are higher among males, middle-age adults, residents in rural areas, and those with mental health conditions.

The most recent available data shows that suicide rates are generally lower among Veterans who use VHA services than among Veterans who do not use VHA services. In 2011, the rate of suicide among those who use VHA services was 35.5 per 100,000 persons per year; a decrease of approximately 6 percent since 2001. Rates of suicide among those who use VHA services have remained relatively stable; ranging from 36.5 to 37.5 per 100,000 persons per year over the past 4 years. Despite evidence of increased risk among middle-aged adults (35-64 years) in the U.S. general population, rates of suicide among middle-aged adults who use VHA services have decreased by more than 16 percent between the years 1999-2010. For males without a

history of using VHA services, the rate increased by more than 60 percent, whereas for males with a history of using VHA services, the rate decreased by more than 30 percent. Decreases in suicide rates and improvements in outcomes were also observed for some other high-risk groups. Between 2001 and 2010, rates of suicide decreased by more than 28 percent among VHA users with a mental health or substance abuse diagnosis, and the proportion of VHA users who die from suicide within 12 months of a survived suicide attempt has decreased by approximately 45 percent during the same time period.[4]

Comparisons of rates of suicide among those with use of VHA services and the U.S. general population are ongoing. However, in 2010, rates of suicide were 31 percent higher among males who used VHA services when compared to rates of suicide among males in the U.S. general population. During that same year, women who used VHA services were more than twice as likely to die from suicide when compared to women in the U.S. adult population. Increases in rates of suicide have also been identified for younger males who use VHA services. Over the last three years, rates of suicide have increased by nearly 44 percent among males under 30 years of age who use VHA services and by more than 70 percent among males who use VHA services between 18 and 24 years of age.

In response to these findings, VA has been focusing on public health and community programming. This includes increased and targeted outreach efforts throughout the country to Veterans and their family members with significant emphasis on safety. We encourage Veterans and their families to learn more about mental illness and to take precautions particularly during times of stress (e.g., properly storing weapons and medications). Being alert to items in the environment that offer potential means of suicidal behavior can make a life-saving difference during a crisis. Messaging and interventions are geared toward those who are most at risk for suicide, including our younger male Veterans, women Veterans, Veterans with mental health conditions, and established patients who are known to be at high risk for suicide. Strategies include specialized training for VHA staff to enhance their recognition and treatment of

[4] www.mentalhealth.va.gov/docs/Suicide_Data_Report_Update_2014.pdf

those at risk, and offering Veterans skills-building and other preventive strategies to address major stressors in their lives. Furthermore, VA is engaged in ongoing research to determine the most effective mental health treatments and suicide prevention strategies. Finally, VA has established the Mental Health Innovations Task Force, which is working to identify and implement early intervention strategies for specific high-risk groups including Veterans with PTSD, pain, sleep disorders; depression, and substance use disorders. Through early intervention, VA hopes to reduce the risk of suicide for Veterans in these high-risk groups.

Readjustment Counseling Service (RCS)

VA's RCS provides a wide range of readjustment counseling services to eligible Veterans and active duty Servicemembers who have served in combat zones and their families. RCS also provides comprehensive readjustment counseling for those who experienced military sexual trauma, as well as offering bereavement counseling to immediate family members of Servicemembers who died while on active duty. These services are provided in a safe and confidential environment through a national network of 300 community-based Vet Centers located in all 50 states (as well as the District of Columbia, American Samoa, Guam, and Puerto Rico), 70 Mobile Vet Centers, and the Vet Center Combat Call Center (877-WAR-VETS or 877-927-8387). In FY 2013, Vet Centers provided over 1.5 million visits to Veterans, active duty Servicemembers, and their families. The Vet Center program has provided services to over 30 percent of OEF/OIF/Operation New Dawn Veterans who have left active duty.

Closing Statement

Mr. Chairman, VA is committed to providing timely, high quality of care that our Veterans have earned and deserve, and we continue to take every available action and create new opportunities to improve suicide prevention services. We appreciate the opportunity to appear before you today, and my colleagues and I are prepared to respond to any questions you may have.